

# Strong Fighting

## Sexual Behavior and HIV/AIDS in the Cambodian Uniformed Services



Family Health International  
Funded by  
The United States Agency for International Development

"The condom can sometimes be broken when we are very strongly  
fighting and changing the style..."

"When we are fighting very strong we do not even know it is broken..."

Discussion among soldiers in Kampong Cham

# **Strong Fighting**

Sexual Behavior and HIV/AIDS in  
the Cambodian Uniformed Services

Prepared for

**FHI/IMPACT Cambodia**

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**December, 2002**



Funded by the United States Agency for International Development ( USAID ) through the IMPACT Project implemented by Family Health International.  
Cooperative Agreement HRN-A-00-97-00017-00

## Foreword

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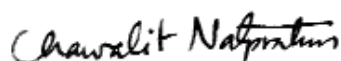
It has become commonplace to suggest that effective HIV/STD prevention interventions are evidence-based. It is less obvious how to go beyond quantitative and surveillance evidence to understand the influence of other factors involved in risk dynamics. The need to "put the flesh on the bones of the BSS" and add to the understanding of the behaviors reported by surveys like BSS is often voiced by concerned implementing agencies. FHI is pleased therefore, to publish "Strong Fighting: Sexual Behavior and HIV/AIDS in the Cambodian Uniformed Services" which provides both the evidence and the context for the design of effective interventions aimed at Uniformed Services and other men in Cambodia.

It begins with a look at Cambodia's history and the social and psychological effects of that history that are essential to understanding the behavior of Cambodian men. It continues with a thoughtful analysis of recent research into the values, complexities and context that provoke HIV/STD risk situations. Its major premise is that sexual behavior is influenced or even determined by the culture in which it takes place. In Cambodia, this means a culture with a history of change and instability, which has led to widespread fear and insecurity.

Finally, the paper explores the variety of personal beliefs held by uniformed servicemen that influence their sexual decision making. These include misconceptions and stigma around condoms, ignorance about HIV transmission methods and inadequate personal risk assessment criteria. The author summarizes by pointing out that exclusive approaches to HIV/AIDS prevention that focus on only one or two factors are unlikely to succeed. Sexual behavior and the determinants of behavior are complex, personal and multifaceted. Successful HIV prevention in the uniformed services must consider these social, cultural, behavioral and personal factors to succeed.

The paper is intended for the many dedicated and concerned workers in the field of HIV/STI prevention and care. We are confident that it will contribute to their ability to explore, understand and more effectively contribute to sexual and personal health.

Phnom Penh  
December 2002



Dr. Chawalit Natpratan  
Country Director  
Family Health International

# Acknowledgements

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This report is a synthesis of ideas. The ideas came from a variety of sources including interviews and reports. This synthesis is neither definitive nor complete. However, without the interest and enthusiastic education provided by the informants listed here this paper would be half as long and twice as naïve. Thanks to the following busy people, who found time to share their ideas and knowledge about high-risk sexual behavior and critique mine:

His Excellency, Dr. Tia Phalla, Secretary General of The National AIDS Authority (NAA)

Dr. Hor Bun Leng, Deputy Director of the National Center for HIV/AIDS, Dermatology and STD (NCHADS)

Dr. Tan Sokkhey, Chief of HIV/AIDS Section, Ministry of National Defense

Va Sopheak, Acting HIV Program Manager, Cambodian Red Cross

Dr. Tawesak Nopkesorn, Thai expert on HIV/AIDS in the uniformed services

Kim Green, HIV/AIDS Coordinator, CARE International in Cambodia

Nami Nelson, Junior Project Officer HIV/AIDS, CARE International in Cambodia

Ettiene Poirot, HIV/AIDS project officer UNICEF Cambodia

Chin Sedtha, Assistant Project Officer HIV/AIDS UNICEF Cambodia

Special thanks also go to Pratin Dharmarak and Dr. Chawalit Natpratan at FHI for coming up with the idea for the paper, for not having time to write it themselves, for sharing their ideas and for constructive comments on the draft report.

Particular thanks to Dr. Song Ngak, Senior Uniformed Services Officer at FHI for being the most important human resource for this report. Dr. Ngak patiently loaned reports, found resources, arranged appointments, answered questions, discussed masturbation, listened to theories and read drafts usually while juggling six other important tasks.

Thanks to my friends, the former sergeant from Military Region II and the Kien Svay policeman who filled in details, explained behaviors and frankly answered countless questions about the culture and habits of the Cambodian uniformed services.

Thanks also to Doung Sarak, Psychologist, translator and amateur linguistic historian who helped to ferret out the meaning behind uniformed services slang.

Finally, thanks to my modest Khmer family who put up with my research for this paper and patiently answered my frequent questions on these immodest topics.

# Contents

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<b>Acknowledgements</b>	ii
<b>Glossary</b>	1
<b>Background</b>	2
Method	4
<b>Introduction</b>	5
The HIV/AIDS Epidemic in Cambodia	5
The Cambodian Uniformed Services	5
HIV/AIDS in the Uniformed Services	6
High Risk Sexual Behavior	7
<b>The Cambodian Context</b>	9
Recent History	9
The Effects of History	9
Commercial Sex in Cambodia	11
<b>Sexual Beliefs and Practices</b>	13
Sexual Norms	13
Sexual Experimentation	14
Myths about Masturbation	17
<b>Factors Specific to the Uniformed Services</b>	18
Culture of Masculinity	18
Working Away From Family	19
Additional Income	20
Personal Invulnerability	21
Culture of Risk Taking	21
Peer Pressure	22
Excessive Alcohol Consumption	23
<b>HIV/AIDS Factors</b>	27
Risk Assessment Based on Partner's Appearance	27
Ignorance about HIV Transmission Methods	29
Acceptability and Availability of Condoms	30
Myths and Misconceptions about Condoms	30
Fear of Already Having HIV	31
<b>Conclusions</b>	33
<b>References</b>	35

# Glossary

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AIDS	Acquired Immune Deficiency Syndrome
BSS	Behavioral Surveillance Survey
CPP	Cambodian Peoples Party
DSW	Direct Sex Worker
FHI	Family Health International
FUNCINPEC	United National Front for an Independent, Neutral, Peaceful and Cooperative Cambodia
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
IMPACT	Implementing AIDS Prevention and Care Project
HIV	Human Immuno-deficiency Virus
HSS	HIV Sentinel Surveillance
IEC	Information, Education and Communication
ISW	Indirect Sex Worker
KAP	Knowledge, Attitudes and Practices
Lao PDR	Lao Peoples Democratic Republic
MoND	Ministry of National Defense
NAA	National AIDS Authority
NCHADS	National Center for HIV/AIDS, Dermatology and STDs
PAC	Provincial AIDS Committee
PAS	Provincial AIDS Secretariat
RCAF	Royal Cambodian Armed Forces
SCHQ	Supreme Command Headquarters (RCAF)
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UN	United Nations
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
UNTAC	United Nations Transitional Authority in Cambodia
USAID	United States Agency for International Development
WHO	World Health Organisation

*Kos kchol*      Called 'coining' in English. Scraping the skin with a disk of metal leaving long red abrasions on the body. It is used to cure nausea, diarrhea, poor circulation and general malaise.

*Yuon*      An impolite and derogatory term for Vietnamese.

*Kbach boran*      Khmer term for sex in the missionary position with the man on top.

*Trant 6*      Infamous foreign sex video reported to be the source of many Khmer men's knowledge of different sexual positions.

*Peday*      Khmer word for men who have sex with men.

*Ktooey*      Khmer word for men who dress or behave like women.

*Munakum*      Khmer word for magic used either as a noun or a verb.

*Srah sor*      Alcohol made from fermented rice.

# Background

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The idea for this paper arose from discussions at FHI/IMPACT Cambodia. The feeling was that something was missing in the body of published work about high-risk sexual behavior among sentinel groups in Cambodia. We felt that the information that was available, the HIV Sentinel Surveillance (HSS), Behavioral Surveillance Survey (BSS) and a variety of smaller scale survey reports were either purely quantitative, had limited analysis or lacked a proper context for the information. It was felt that the quantitative data on sexual risk behavior, number and types of sexual partners, frequency of sexual contact and rates of unprotected sex needed to be considered in the context of Cambodia and not in isolation. Further, it was felt that the factors that influence these behaviors, the culture, customs, history and socio-economy of Cambodia needed to be considered to properly understand the behaviors. In addition, previous analysis of risk behavior in Cambodia was felt to have too much of an international flavor and less of a Khmer flavor. Therefore, we proposed to analyze these behaviors from a Khmer context by discussing some of the cultural factors that influence the behavior.

In analyzing the behaviors and the culture behind them, the author relied heavily on the important work of Ms. Chou Meng Tarr. A Cambodian sociologist, Tarr conducted a two year field research project in Phnom Penh and Kandal in the mid 1990's. Her research aimed to explore the social and contextual factors affecting risk related sexual activities. It was hoped that this information would inform the development of more realistic interventions to reduce the incidence of HIV infection in Cambodia. Introducing her study Tarr states:

*"Repeatedly I came across simplistic assertions about the nature of a gender symbolism in Cambodian culture that accords much greater sexual autonomy to males than females and how it impacts upon sexual behavior in present day Cambodia. Apart from being ethnographically unsophisticated, much of this research was highly quantitative in nature."*<sup>1</sup>

Six years later we have aimed to present a more sophisticated view of high-risk sexual behavior. In short, the paper was conceptualized as 'putting the flesh on the bones of BSS' and adding to the understanding of the behaviors reported by surveys like BSS. The author makes no claim to a definitive understanding of the Khmer culture. However, the concepts explored and reported in the paper were conceived and crosschecked with Khmer and expatriate professionals working in the HIV sector.

The aim of the investigations and analysis reported in this paper is to present an inclusive discussion of the factors that influence risky sexual behavior, rather than an exclusive one. There is no attempt to rank factors in order of importance or to quantify them to any great extent. Many of these factors, like visits to commercial sex workers, alcohol consumption and condom availability are well known and have been investigated by numerous studies. Other factors like the opportunities and obligations of hidden income or Khmer attitudes to various sexual positions are less widely known and are discussed here in more detail.

The primary HIV transmission method for the military and police in Cambodia is unprotected sex with a partner other than a wife. Based on this premise, the following diagram illustrates the main factors examined in the paper and the links between them.

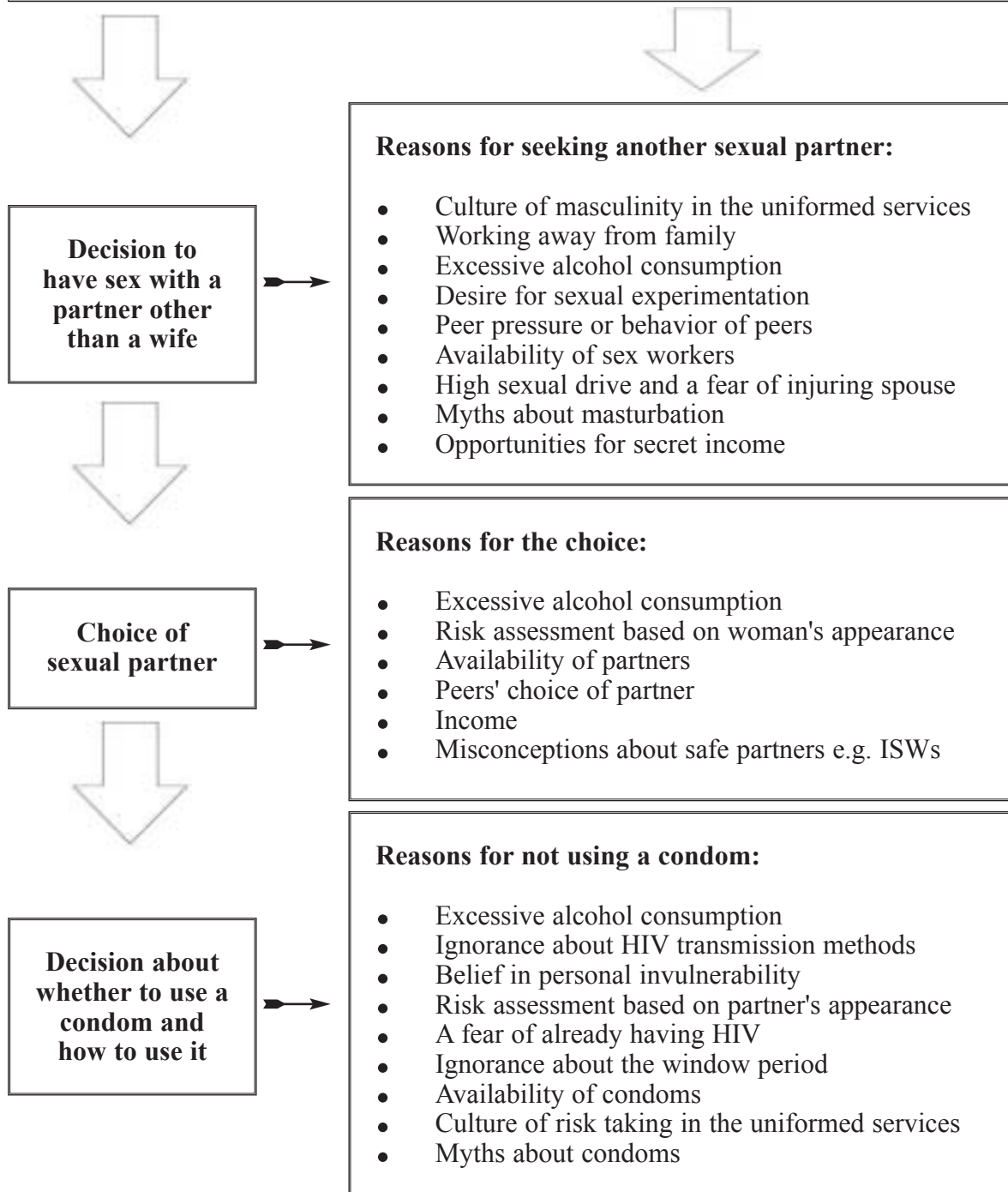
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<sup>1</sup>Tarr (1996)



## The Cambodian Context

Short term rather than long term thinking due to extended crises  
Social and community ties weakened by war, migration and poverty  
System of extended families weakened by war, migration and poverty  
Patriarchal society that excuses men's sexual experimentation  
Government law enforcement corrupt and ineffective  
Massive influx of western culture and ideals in the last ten years  
High mobility due to poverty



## Method

The information reported in the body of the report was gathered from three main sources. Firstly, a literature review was conducted through organizational libraries in Phnom Penh. The review focussed on sexually transmitted diseases in the military, the sex industry and sexual attitudes, beliefs and behaviors. There is a large body of published work on HIV/AIDS in Cambodia and on the sex industry. However there are relatively few published reports on HIV and the Cambodian military or police. This no doubt reflects the fact that only a few organizations have sustained programs with this group. Because of this lack of published material, some research from other countries was collected. This report relies heavily on reports from Family Health International (FHI), CARE International and the Ministry of National Defense (MoND).

The second method was a series of discussions with professionals working in the HIV/AIDS sector in Cambodia. Again, the emphasis was on those familiar with work on the Cambodian military and HIV/AIDS. Some of these informants were consulted more than once to cross check information or hypotheses that arose during the course of writing the paper. The considerable experience of Dr. Song Ngak at FHI, Dr. Tia Phalla at the NAA and Dr. Hor Bun Leng from NCHADS was particularly useful in this regard.

The third source of information was individual interviews and focussed group discussions with 135 uniformed services personnel collected by FHI. These interviews were collected in 2000 and 2001 as part of FHI's ongoing program monitoring and supervision. They were retained and used in the preparation of this paper although they were not collected for this purpose. These interviews had an important advantage over many similar studies. The interviewers were male Khmer and were other uniformed servicemen. The results of these dynamics are a series of unusually frank and detailed discussions about sexual behavior, attitudes and preferences among uniformed servicemen.

In essence, the following discussion addresses three questions:

- *Why do Cambodian uniformed servicemen have extramarital sex?*
- *Why do they have unprotected sex?*
- *What is the social and cultural context for these behaviors?*

# Introduction

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## The HIV/AIDS Epidemic in Cambodia

Many countries have been grappling with HIV and AIDS since the 1980's. By comparison, the Cambodian epidemic is a relatively new one. The first recorded case of Cambodian HIV was identified in 1991 during regular screening at the National Blood Transfusion Center in Phnom Penh. The first case of AIDS was reported to the Ministry of Health in 1993. Cambodian HIV surveillance started in 1992 through the National Centre for HIV/AIDS, Dermatology and STDs (NCHADS). In that year a relatively small sample (n=207) of commercial sex workers were tested in Phnom Penh. The testing revealed that nine per cent were already infected with HIV. Throughout the 1990's, the rate of HIV infection continued to climb and by 1997, there were estimated to be 210,000 adults living with HIV in Cambodia. By 1998, Cambodia was considered to have one of the most serious AIDS epidemics in Asia. In 1999, HSS (HIV surveillance survey) studies found a prevalence rate of 2.6% among pregnant women. This indicated that the Cambodian epidemic had spread from specific core groups into the general population and categorized Cambodia's epidemic as 'generalized'.<sup>2</sup>

National HIV sentinel surveillance in 1999 found prevalence rates of 1.8% percent among males and 1.2% percent among females in the general population. In recent years, the trend has been improving. The number of people estimated to be living with AIDS was 169,000 in 2000 meaning that the number of new infections is lower than the number who die from AIDS each year. The latest figures for HIV prevalence show infection rates declining or stabilizing among all sentinel groups except for indirect sex workers.<sup>3</sup>

Increased knowledge and awareness of HIV/AIDS and declining rates of HIV prevalence appear to demonstrate the success of the government's multi-sectoral approach to HIV/AIDS prevention and care. In light of these positive signs, Cambodia has recently attracted increased funding from National governments and the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) for HIV/AIDS prevention and care. In this current atmosphere with a strong focus on HIV/AIDS, the government and partners are looking to expand or scale up successful interventions to bring the Cambodian epidemic under control.

## The Cambodian Uniformed Services

Cambodia has a long history of conflict. In December 1998, the last of the Khmer Rouge surrendered to government forces ending more than forty years of continuous fighting within the country. One of the legacies of this extended conflict was a large Cambodian military. The ranks of the military were further swelled in the late 1990's as thousands of former Khmer Rouge soldiers joined the government and were sworn into the Royal Cambodian Armed Forces (RCAF).

The RCAF consists of the Supreme Command Headquarters (SCHQ) located in Phnom Penh, three distinct forces, the army, navy, air force and the military police. The army is the largest force with troops stationed in each province of the country. The Navy is the second largest force and operates at sea, along the Mekong and Bassac rivers and in the Tonle Sap Lake. The military police force numbers around 2,200 employees and runs

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<sup>2</sup> Cambodia's Behavioural Surveillance Survey 1997-1999, NCHADS.

<sup>3</sup> Report on HIV Sentinel Surveillance in Cambodia 2000, NCHADS.

parallel to the civilian police force. The military police have posts in every province and municipality across the country. The air force is the smallest of the forces and has around 1,000 employees. The air force operates in every province with an airport.<sup>4</sup>

The RCAF is divided geographically into five military regions and one special region. Each region includes several sub regions that correlate to civilian municipal and provincial boundaries:

- Region One: Headquarters are in Stung Treng and the region covers the provinces of Stung Treng, Ratanakiri and Mondulakiri.
- Region Two: Headquarters are in Kampong Cham and the region covers the provinces of Kampong Cham, Prey Veng, Svay Rieng and Kampong Thom.
- Region Three: Headquarters are in Kampong Speu and the region covers the provinces of Kampong Speu, Takeo, Kampot, Sihanoukville, Koh Kong and the municipality of Kep.
- Region Four: Headquarters are in Siem Reap and the region covers the provinces of Siem Reap, Odder Meanchey and Preah Vihear.
- Region Five: Headquarters are in Battambang and the region covers the provinces of Battambang, Pursat, Banteay Meanchey and the municipality of Pailin.
- Special Region: Headquarters are in Phnom Penh and the region covers the provinces of Kampong Chhnang, Kandal and the municipality of Phnom Penh.

Prince Sisowath Sirirath, Co-Minister of Defense recently stated that the Cambodian military stood at 111,232 persons.<sup>5</sup> With the end of fighting and the surrender of the last of the Khmer Rouge, the Cambodia military has been undergoing substantial changes as it shifts to become a peacetime force. Since 1999, the government has been working to demobilize large numbers of servicemen. Demobilization efforts began in February 2000 and the first 1,500 soldiers were demobilized in a pilot project later that year. In 2001, the first phase of demobilization got underway and 15,000 soldiers returned to civilian life in large ceremonies around the country. In the second phase of demobilization, planned for 2003, an additional 30,000 servicemen will leave the armed forces. In addition, the Ministry of National Defense (MoND) is restructuring to rationalize the deployment of the reduced forces available after demobilization.

### **HIV/AIDS in the Uniformed Services**

The military and the police were selected as sentinel groups for HIV prevalence research because of the high-risk sexual behaviors common to these groups. The most important of these factors are the frequent purchase of commercial sex and inconsistent condom use. The following table shows the prevalence rates recorded by sentinel surveillance for the military and police since 1992. HIV prevalence rates for direct and indirect sex workers are included for comparison:

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<sup>4</sup> HIV/AIDS and the Military - Draft Situation and Response Analysis Report 2001. FHI.

<sup>5</sup> Cambodia Daily 3/9/02.

Sentinel group	1992	1994	1995	1996	1997	1998	1999	2000	2002
Police	0%	-	8%	5.5%	6%	6.2%	4.7%	3.1%	3.9%
Military	0%	-	5.9%	5.9%	7.1%	-	-	-	-
Indirect sex workers	-	-	25.3%	-	-	19.1%	18.6%	16.1%	14.8%
Direct sex workers	9%	39%	38%	40.9%	39.3%	42.6%	33.2%	31.1%	28.8%

Source: HSS 2000 and 2002, NCHADS

The military and police were first included as sentinel groups in 1992 when they recorded zero prevalence figures. In 1995, the police prevalence rate peaked at 8 per cent while the military recorded rates of 5.9 per cent. Infection rates for the military peaked in 1997 at 7.1 per cent. The military were discontinued as a sentinel group after 1997 due to reorganization within the military. Since 1998 only police have been tested each year on the assumption that their risk behaviors (measured by BSS) and previous prevalence rates were similar. HIV prevalence rates for police have shown a steady improvement since 1998. The national figures in 2000 show the HIV prevalence rates for police was 3.1 per cent. However, these figures varied considerably between provinces from 0.7 per cent in Svay Rieng to 10.7 per cent in Koh Kong.

The Ministry of National Defense has responded to the HIV/AIDS epidemic with commitment and commendable alacrity. MoND is considered the most advanced ministry apart from the Ministry of Health in its response to HIV/AIDS. HIV/AIDS and STD prevention efforts began in 1995 with support from the United Nations Development Program (UNDP). Peer education and advocacy activities began in two pilot provinces in 1997. In 1998 this program was expanded with support from the World Health Organisation (WHO), Family Health International and other international NGOs. MoND has also played an active role in the national HIV/AIDS response. Since 1997, the sub regional commands have been members of the Provincial AIDS Secretariat (PAS) and Provincial AIDS Committees (PAC). MoND has also been represented on the technical and policy boards of the National AIDS Authority (NAA) since it was set up in 1999.<sup>6</sup>

### High Risk Sexual Behavior <sup>7</sup>

High-risk sexual behavior in Cambodia has been investigated annually since 1997 by the Behavioral Surveillance Survey (BSS). The BSS serves to complement the HIV prevalence survey by tracking trends in the behaviors that place people at risk of contracting HIV/AIDS. The BSS is a series of repeated regular surveys conducted in five cities. The BSS aims to quantify these behaviors and make it possible to measure change over time. The BSS repeatedly investigates sexual behavior among the same male and female sentinel groups each year. The female groups are direct and indirect sex workers (DSW and ISW) and male groups include the uniformed services (military and police) and motorcycle taxi drivers.

Condom use is one of the most important behavioral indicators measured in the BSS. The most recent round of the BSS shows that DSWs report that condom use with clients has increased from 37.4 per cent in 1997 to 89.3 per cent in 2001. For ISWs the change is more modest but still impressive from 10 per cent in 1997 to 56.3 per cent in 2001. The government's 100% condom use policy has been actively pursued in brothels across the country and seems to have been successful in increasing condom use among direct sex

<sup>6</sup> HIV/AIDS Strategic Plan 2002-2006 Ministry of National Defence.

<sup>7</sup> Figures used in this section are taken from BSS V 2001, Trends from 1997-2001, NCHADS.

workers. At the same time, male sentinel groups have reported more consistent condom use with DSWs. In 1997, only 42.9 per cent of military respondents reported always using condoms with DSW and by 2001, this had increased to 86.7 per cent. For police respondents, reported condom use has changed from 65.4 percent in 1997 to 85.1 per cent in 2001.

Other sexual behaviors have also been changing over time. Uniformed servicemen report less sex with DSWs. In 1997, 75.8 per cent of military respondents reported sex with a DSW in the past year. By 2001, this had declined to 32 per cent. The figures for the police are almost identical. At the same time, more indirect sex workers report selling sex. In 1997, only 12.8 per cent of respondents reported selling sex and by 2001 this had risen to 30.4 per cent of respondents. More indirect sex workers also reported sex with sweethearts. In 1997, 46.7 per cent of ISWs reported sex with sweethearts. By 2001 99.5 per cent of respondents reported sex with sweethearts.

In general, more uniformed servicemen report sex with non-marital, non-commercial partners. In 1999, 30.8 per cent of all men surveyed (military, police, moto taxi drivers) reported having sex with a sweetheart. By 2001, this had increased significantly to 73.1 per cent. Consistent condom use with sweethearts has not increased at the same rate as condom use with commercial partners. In 1999, only 12.2 per cent of all men surveyed reported consistent condom use with sweethearts. By 2001, this had increased to only 20.7 per cent.

Overall, BSS has recorded a number of changes in risk dynamics since 1997. Reported condom use has increased across all sentinel groups since 1997. Fewer men report commercial sex in the past year. All sentinel groups reported increased sexual activity with non-commercial non-marital partners. Condom use with ISWs and sweethearts has increased but remains low particularly for sweethearts. Some trends from the HIV sentinel surveillance are also relevant here. Overall, the HSS has measured a decline in HIV prevalence in all sentinel groups except for indirect sex workers who have remained essentially the same.<sup>8</sup> These changes have prompted organizations to explore ways of reducing the risk of HIV infection through indirect sex workers and sweethearts.

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<sup>8</sup> Report on HIV Sentinel Surveillance in Cambodia 2000, NCHADS



# The Cambodian Context

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## Recent History

Cambodia has a unique history even within South East Asia. In the space of thirty years, Cambodia has seen a progression of widely varying political and social systems. From a popular monarchy in the sixties to an American backed Khmer Republic brought about by a coup d'etat in 1970. This regime lasted less than five years before being replaced by the radical communism of the Khmer Rouge. Three and half years later the Khmer Rouge government were overrun by the Vietnamese army. They in turn installed a less extreme communist republic which governed the country for the next ten years. The Vietnamese withdrew in 1989 and for the next two years various groups wrangled for power until the Paris Peace agreement in 1991 paved the way for a United Nations peacekeeping mission. The United Nations Transitional Authority in Cambodia (UNTAC) was the largest UN peacekeeping mission in history and administered the preparation for general elections. At the time of the elections in 1993, all the previous groups who had held power in Cambodia, with the exception of the Lon Nol government, were still struggling for power. The royalist party (FUNCINPEC) won the elections but the threat of renewed fighting led to a compromise between the former Vietnamese backed government (CPP) and the royalist party to form a coalition government headed by a first and a second Prime Minister. This uneasy coalition lasted for four years before fighting again broke out in the capitol and the first Prime Minister and many of his supporters fled to Thailand. After nearly a year in exile, the royalist first Prime Minister returned to the country in time to contest general elections in 1998.<sup>9</sup> The CPP won a narrow majority in the second general election and Cambodia became headed by a single Prime Minister. In December 1998, the last of the Khmer Rouge surrendered to the government. The end of the Khmer Rouge represented the first time Cambodia had been without armed insurrection within its borders for more than forty years.

Although this history is necessarily incomplete, it serves to demonstrate the extent and frequency of change in Cambodia. Armed conflict, famine, disease, internal and external migration and widespread social change have been a part of Cambodia since at least the 1970's and probably longer. No other South East Asian nation has undergone so many extreme changes in such a short space of time. Understanding Cambodia's history and the social and psychological effects of this history are essential to understanding the behavior of Cambodian men. For the men of the Cambodian uniformed services this history is particularly relevant. Many of the uniformed services have been closer to Cambodia's violent and disruptive past than most Khmer. The uniformed services have been responsible for fighting the wars, maintaining the peace, protecting the laws and implementing the apparatus of changing regimes. Fear, instability and insecurity have characterized Cambodia's recent history. Not surprisingly, this atmosphere has effected the people and their behavior. Many of these effects are relevant to HIV/AIDS prevention and understanding the dynamics of high-risk sexual behavior.

## The Effects of History

One of the psychological effects of Cambodia's disrupted past has been a reliance on short term rather than long-term thinking. Quantifying subjective perceptions and beliefs like personal safety and confidence in the future is difficult and most attempts to do this in Cambodia have been small scale. However, a recent regional opinion survey by the

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<sup>9</sup> Kamm (1998).

United Nations Children's Fund (UNICEF) shows some suggestive comparisons between Cambodia and other countries in the region. Children between 9 and 17 years were asked a variety of questions about their views, opinions and how they saw the world. The survey was conducted in 2001 with 10,073 children from 17 countries in East Asia and the Pacific. Face to face interviews were conducted with children in Australia, Cambodia, China, East Timor, Hong Kong, Indonesia, Lao PDR, Macao, Malaysia, Mongolia, Myanmar, Papua New Guinea, Philippines, Korea, Singapore, Thailand and Vietnam. In Cambodia 508 children were interviewed in both rural and urban settings.<sup>10</sup>

During the survey, children were asked how safe they felt in their immediate community in the nighttime and during the day. On average, only six per cent of all the children surveyed felt unsafe in their communities during the day compared to 15 percent of Khmer children. Only Mongolia recorded a higher percentage than Cambodia at 26 per cent. On average 57 per cent of all the children surveyed felt very safe in the daytime. However, only 14 per cent of the Khmer children surveyed felt very safe in the daytime. This was the lowest percentage for any country in the survey. By comparison 65 per cent of Thai and Vietnamese children and 70 per cent of Lao children reported that they felt very safe during the day. In the nighttime 28 percent of all the children surveyed reported that they felt safe. However, only four per cent of Khmer children reported that they felt safe and 54 per cent felt unsafe at night. Again, these were the most extreme figures for any of the countries surveyed.<sup>11</sup>

Children learn their perceptions of safety and security from the environment and from the people around them. It might be argued that Khmer children have faced more dangers than other countries and therefore their perceptions of personal safety are accurate and not exaggerated. The oldest Khmer children surveyed would have been born in 1984 and the youngest in 1992 and they would have no personal memories of the Khmer Rouge years, bombing or the civil war. Despite being born and living in the most stable period of Cambodia's recent history, Khmer children report that they are more frightened than any other children in the region. By comparison, East Timor is a country with a recent history of fear and violence. The 512 East Timorese children surveyed have probably lived through more death, violence and fear in recent years than the Khmer children surveyed. Despite this, 88 per cent of the East Timorese children reported that they felt very safe in the daytime compared to only 14 percent of the Khmer children. It seems that Khmer children reported something more than an objective assessment of personal safety. The author suggests that this finding is indicative of a pervasive feeling of fear and insecurity.

This insecurity also manifests itself in thinking about the future. Children in the UNICEF survey were also asked about their lives in the future. Specifically they were asked if their lives would be better or worse than the lives of their parents. Overall, 81 per cent of children in the region believed that their lives would be better than their parent's lives. This reveals an encouraging belief in a bright future for the children surveyed. However, only 54 per cent of Khmer children believed that their lives would be better than their parent's lives, the lowest percentage of any of the countries surveyed. By comparison, 92 per cent of Vietnamese children and 85 per cent of Thai children believe that their lives will be better than their parent's lives were.<sup>12</sup>

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<sup>10</sup> UNICEF, 2001.

<sup>11</sup> Ibid.

<sup>12</sup> Ibid.



A concrete example of this pervasive fear and distrust of stability occurred in Phnom Penh in late 2000. Late at night a group of twenty or so armed men fired shots at several government buildings and then fled the city. The disturbance occurred late at night and most Phnom Penh knew nothing of the attack or only heard distant gunfire. Despite several years of relative stability, at eight o'clock the following morning the streets of Phnom Penh were virtually deserted. Shops and offices were closed and throughout the day people hid in their homes and waited for news. Three days after this incident many shops and offices remained closed and traffic had not returned to previous levels. Compare this to the reaction of New York citizens after the far more destructive World Trade Center attacks.

Several generations of Cambodians have learnt the lessons of their own history - that life is uncertain, perilous and stability is not to be trusted. This is true for most Khmer but particularly relevant for the uniformed services who have been closer to Cambodia's recent history than most Khmer. The latest phase of Cambodian history is only four years old. This is less than half the period of relative stability during the Vietnamese occupation. This has not been long enough to disperse the pervasive fear and insecurity of the past.

This short-term thinking has obvious implications for preventing HIV and AIDS. For people who look forward to the next few days or months a virus that kills years later is an abstract danger that is difficult to consider. A Phnom Penh sex worker expressed this attitude succinctly in a 1999 study of sexual practices:

*"If I have no money to buy food, I will die in one week. But if I contract HIV I will die five years later."*<sup>13</sup>

For those who view every day as a struggle to survive, potential death from AIDS years later is an irrelevant abstraction. This kind of thinking is common in Cambodia even for those who no longer have to fear immediate death or starvation. It is a habit of thinking that is difficult to break. Many Khmer are uncertain about the future and this makes it difficult to consider the long-term effects of behavior. Weighing the dangers of AIDS against the immediate gain of sexual satisfaction requires long-term thinking. Long-term thinking in turn is a luxury that can be afforded by those whose needs are secure. In Cambodia, these people are few. Most Khmer have learned very well that today's relative security may be snatched away in an instant by disease, drought, flood, ill fortune or violence.

For the uniformed services, this short-term thinking influences many decisions and behaviors that are relevant to HIV/AIDS prevention. Examples include extra-marital sex, heavy drinking and sex without a condom. Later sections of this paper will examine these behaviors.

### **Commercial Sex in Cambodia**

Availability is a contributing factor to high-risk sexual behavior in Cambodia. This is not to suggest that sex workers are responsible for high rates of commercial sex. Without demand for commercial sex, sex workers could not make a living. However, aspects of the Cambodian sex industry make it distinct from other countries and are worth considering. These aspects contribute to the attraction, respectability and deniability of extramarital sex for Khmer men.

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<sup>13</sup> Vathanak (1999).

Since 1995, the National Centre for HIV/AIDS, Dermatology and STDs has been collecting data on the numbers of sex workers in Cambodia. The data has been collected annually, in recent years by the Provincial AIDS Committees in each province. Data collection methods have developed and been refined each year so accurate comparisons between years are not possible. NCHADS also believes that the numbers are probably an under representation of the true numbers of sex workers. Due to the logistical difficulties involved in collecting this data, it takes several months for complete figures to become available and by the time they are published; they are probably out of date. These difficulties notwithstanding, it is clear from the figures that Cambodia has a flourishing sex industry, both direct and indirect.

In 2001, NCHADS reported 2,356 sex establishments in Cambodia and 12,290 sex workers in 23 of 24 provinces and municipalities (Oddar Meanchey was not surveyed). These figures may not seem extreme for a population of around twelve million but some comparisons may be illuminating. There are less than a thousand public health facilities in Cambodia compared to 2,356 sex establishments and there are four times as many sex workers as there are qualified doctors in the country.<sup>14</sup>

The popular image of commercial sex is a singular activity, conducted in isolation - clients visit sex workers to have sex, not to enjoy other recreational activities. However, in Cambodia commercial sex can be combined with eating, drinking, dancing, karaoke, massage, snooker or coining.<sup>15</sup> All of these activities are popular pastimes among Khmer men and many establishments catering to these diversions also employ young women who are either direct or indirect sex workers. The ability to combine entertainment options, for example by enjoying a meal and dancing or drinking and karaoke with the opportunity for commercial sex is an important motivating factor for Khmer men.<sup>16</sup> It also adds to the social acceptability and deniability of purchasing sex. Men who are reluctant to visit a brothel through embarrassment or a fear of being seen can have a meal with friends at a restaurant with hostesses or beer promotion girls without fear of censure.

Sex is cheap in Cambodia and prices are relatively stable. BSS V reports the median cost of sex from commercial sex workers as around 5000 Riel (\$1.25).<sup>17</sup> By comparison, an investigation of sex workers in Phnom Penh during the UNTAC period recorded prices of 5000 Riel for brothels in Tuol Kork and Boeng Salang.<sup>18</sup> This price puts commercial sex within the reach of most Cambodian men.

In many countries, commercial sex is conducted in relative secrecy due to its legal status or lack of social acceptability. In Cambodia, sex can be negotiated readily in all major population centers around the country. Price and opportunity also play a role in the popularity of commercial sex. Where sex workers are available, located close by and sex is relatively cheap the rate of commercial sex can be assumed to be higher than if there were few sex workers, who were difficult to find, located far away and expensive. These factors do not create the demand for commercial sex rather they are they expression of the demand. However, these factors are part of the context for sexual risk taking in the uniformed services. They also affect HIV/AIDS prevention and care and the messages that are used to change high-risk sexual behaviors.

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<sup>14</sup> Program for Appropriate Technology in Health, 2002.

<sup>15</sup> Kos Kchol - literally "scraping away the wind." It involves scraping the skin with a disk of metal leaving long red abrasions on the body. Kos Kchol is used to cure nausea, diarrhoea, poor circulation and general malaise.

<sup>16</sup> Sex is as Essential as Rice, CARE (2002).

<sup>17</sup> Behavioural Surveillance Survey 2001, NCHADS (2002).

<sup>18</sup> Men are Gold, Women are Cloth, CARE (1993).

# Sexual Beliefs and Practices

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## Sexual Norms

Monogamy in Cambodia is a relatively recent innovation. Before 1975, polygamy was accepted under the Cambodian civil code. Husbands were permitted to have more than one spouse and wives were ranked on marriage certificates as first wife, second wife etc. The Khmer Rouge abolished all previous laws in 1975 and the Vietnamese backed Republic that took power in 1979 did not reintroduce the code. However, polygamy remains legal for the Muslim Cham minority under certain circumstances.<sup>19</sup> The concept of polygamy did not perish with the law. Cambodian men still talk or dream of second wives. The following excerpt is from a discussion among married police in Phnom Penh:

*Facilitator: "What do you think about having many, that is, more than one wife?"*

*Participant 1: Under Cambodian law, it is not right. The law states that a man shall have no more than one wife.*

*Participant 2: Under the constitution, a man shall have only one unique wife. But now if you have more than one, that is your business, your secret.*

*Participant 3: It is actually not prohibited, but we have to be personally responsible for problems if we have more than one.*

*Participant 4: Mr. Choy has two wives. The two wives even live together in harmony.*

*Participant 5: An old man, a fortune-teller, has up to 8 wives and 37 family members.*

*Participant 2: For me personally, I would not mind if I could have 30 wives.*

*Participant 1: In the past, only a few men would have more than one wife. Now many men do. It is because women now outnumber men."*

In some sections of Cambodian society, it is expected that men will have sexual partners outside of marriage even if it is not openly condoned or acknowledged. There are prominent role models for this behavior - wealthy public figures have widely publicized affairs and breakups with extramarital partners. In her 1996 study into the context for sexual risk behavior, the noted Cambodian Sociologist Chou Meng Tarr states:

*"Almost without exception there is an expectation that both before and after marriage Cambodian males will seek out multiple sexual partners, but the critical factor is whether these partners are defined as those whom one enters into a sexual relationship with. Cambodian females do not appear to recognize the paid sex worker as a female whom a male has entered a relationship with. Such brief sexual encounters are mostly considered to be part of the socializing practices of males, both single and married, or a legitimate activity that married males can engage in when their spouses are unavailable for sexual activity, such as just prior to and immediately after childbirth, during a long illness, or during menstruation."*<sup>20</sup>

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<sup>19</sup> Tarr, (1997).

<sup>20</sup> Tarr, (1996).

The following quote from a married police officer in Phnom Penh illustrates this attitude among Cambodian uniformed servicemen:

*"The adultery of the wife is very wrong and we cannot accept it. For the whole life of a man, if the wife commits adultery one time then the man is angry and we must divorce. However, if the man has sex outside secretly and his wife knows, we just have a little bit of an argument and the husband says sorry and it is finished."*

Sexual norms in the uniformed services are similar to those for other Cambodian men but there are important differences. Extra-marital sex and heavy drinking are more common. In the uniformed services, these are the two most important recreational options. During participant research conducted by FHI in 2000, military and police officers were asked about the activities that they enjoyed when they were not working. Respondents were equally divided between police and military officers. The table below shows the preferred outside entertainment reported by all respondents. Respondents commonly gave more than one answer so that percentages add up to more than 100.

Entertainment	Percent
Have sex/ go to a brothel	83%
Drink alcohol	51%
Go out to eat	25%
Sing karaoke	24%
Don't go out for sex/stopped going out	17%
Go out for a massage	3%
Go for a walk	3%
Play cards/gamble	2%
Dancing	2%
Watch pornographic videos	2%
Drink soft drink	2%

**Table 1: Outside Entertainment**

Most respondents reported that they went out for sex. Many of these specified that they went to brothels although some did not say where they went except to say 'outside'. Although sex was the most common form of entertainment mentioned, most respondents mentioned more than one activity that they enjoyed. Respondents described their outside entertainment which usually began with some other activity and ended with having sex. The most common combination was going out to drink, then going to have sex. Only 17 per cent of respondents reported that they did not go out for sex or did not go out at all and most of these were police respondents. A few respondents reported other activities like going for a walk, having a massage, playing cards, dancing or watching videos. Most of these activities also ended with having sex. Generally, respondents reported a limited range of entertainment activities. Drinking alcohol and having sex were easily the most common activities. Only 8 per cent of participants did not report either drinking or having sex in answer to this question.

**Sexual Experimentation**

During participant research at FHI, uniformed servicemen were asked about preferred sexual positions. The discussions that were recorded revealed some interesting findings about the motivations for extra-marital sex. Most participants reported that the missionary position i.e. the man on top, was the only normal or acceptable sexual position with wives.

This position has many names in Khmer although the most common are 'kbach tormadah' and 'kbach boran'.<sup>21</sup> Despite this, all participants were aware of other sexual positions. Many participants reported that they had learned about these styles from a foreign video called '36 Positions' or 'Video 36'.

*"I cannot use any severe sexual techniques. But sometimes with prostitutes, I like to use the techniques I saw on trant 6 film, like doggy style or the woman above."*

This video has achieved almost legendary status in Cambodia. In the results of a 1995 study, Chou Meng Tarr reports that one of her informants received his information about sexual positions from watching Video 36 in 1989 and that the video was banned the following year.<sup>22</sup> The uniformed servicemen interviewed reported enjoying different sexual activities during sex as in the following quote from a police respondent:

*"Some days when I have no money, I usually have sex as usual at Toul Kork and Svay Pak. When I have money, I like to go to the place that serves something strange to make me more comfortable. If we have money like 7,000 or 10,000 Riel, we can order what we want. Like one day, I asked the yuon (an impolite term for Vietnamese) girl to suck and lick from the tip of my leg up to my head especially the ticklish places like my neck and hips. The feeling is comfortable because sucking makes me come to the top (orgasm) and I can touch the vagina of the yuon girl and me she sucks with her mouth like eating ice cream."*

Despite the widespread knowledge of different sexual positions and activities, respondents were unanimous in reporting that they only used the 'normal' position during sex with their wives. The reasons for this varied. Some respondents believed that different sexual positions could damage a woman's health as in this example from a military respondent:

*"Using different positions is very dangerous. For example, somebody's penis may be long or short. So when we use many positions it can destroy the health and damage the womb. With the prostitute girls, I always use different positions, with the other girls but not with my wife."*

Other respondents reported that their wives were not experienced and did not know any other sexual techniques like this police respondent:

*"I remember when I studied in Vietnam I also used to play with the Vietnamese girls in the 1980's. Having sex with my wife every time I feel not very comfortable, but if we try outside girl, they have their good techniques."*

Finally many respondents believed that it was improper, not right or impolite to use different sexual positions with their wives as in this quote from a military respondent:

*"For my own personal thing when I have sex with my wife, that is normal, we can not compare our wife with the prostitute girls. So during we have sex we do normal in accordance with our behavior. We can not lift feet or hand, plowing style like the other's said because this is only use for prostitute girls, bar girls, dancing girl or promotion girl that make money from this. But for our family, we can not do like this. If we do like this, it is a very bad look. We are not polite to our wife."*

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<sup>21</sup> The English translation would be 'normal style' and 'ancient style'

<sup>22</sup> Tarr, C.M. *Imagining Desire*. (1997).



These beliefs are not new and are not limited to the uniformed services. The CARE study in 1993 mentioned earlier contains a quote from a young married woman who reported that men liked visiting prostitutes because they were more sexually experienced than their wives.<sup>23</sup> In the results of her 1996 research, Chou Meng Tarr also reported that her young male respondents enjoyed visiting Vietnamese prostitutes because they would agree to sexual activities that Khmer women would refuse.<sup>24</sup>

Frequent sexual intercourse is considered masculine in Cambodia as it is in many cultures. Frequent means three times per day or even more. A low sexual drive or apparent lack of desire, may be construed as not masculine or even a sign of incipient homosexuality. The derogative slang words '*peday*' and '*ktooe*'<sup>25</sup> are often jokingly used in conversation for males who display unmasculine behaviors, dress or language. At the same time, there is a belief among some uniformed servicemen that frequent intercourse is detrimental to a woman's health.

These sexual beliefs, that only the missionary position is normal, that Khmer wives would not agree to other sexual positions and that 'severe positions' are impolite, disrespectful or even dangerous contribute to the acceptability of extra-marital sex generally and sex with commercial sex workers in particular. Realistic or not, these beliefs are used by many uniformed servicemen to differentiate and rationalize sex with different partners. The following quote from a police officer summarizes the argument against sexual experimentation within marriage.

*"I have to respect her and I also have to treat her well. Also, I am afraid of making her have problems with her health after sex. I mean that if I have sex with my wife with severe techniques, sometimes it could make her hurt and then she could possibly get an unexpected disease."*

It was not possible to determine how widespread these myths are or whether they were shared by informants wives. However, whether this belief is a convenient justification for extra marital sex or a genuine desire to avoid injuring ones wife is not important. This belief is one of the ways uniformed servicemen rationalize extra-marital sex and worth considering in HIV/AIDS prevention. Professionals working in HIV prevention in Cambodia have acknowledged these factors for some time. During the informant interviews for this paper, two organizations, CARE and NCHADS, reported that they promote communication about sex between spouses in HIV/AIDS education partly to address the issues above and in the hope of promoting more open communication about sex in general.<sup>26</sup>

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<sup>23</sup> Men are Gold, Women are Cloth, CARE (1993).

<sup>24</sup> Tarr, C.M. Imagining Desire. (1997).

<sup>25</sup> The English equivalents would be 'poof' and 'transvestite'.

<sup>26</sup> Interviews with Kim Green, CARE International 10/6/02 and Dr. Hor Bun Leng, NCHADS 27/5/02.

## Myths about Masturbation

Masturbation is not considered appropriate for Khmer men. In young children it may be considered acceptable or normal as part of sexual development. However, for adult men it is not acceptable. It has connotations of being a child's activity and therefore is inappropriate and unmanly for an adult male. As in most countries, there are common myths about masturbation in Cambodia; perhaps the most common is that it decreases mental powers. For married men who already have sexual partners masturbation is even less justifiable. As noted earlier extra-marital sexual partners are widely considered an option when a wife is unable to have sex. At best male masturbation is considered a second rate sexual activity compared to sexual intercourse.<sup>27</sup>

Notwithstanding these considerations, Cambodian men do masturbate as many of the informants for this paper agreed. Some researchers have argued that masturbation is acceptable in Cambodia but is not widely practiced by men and definitely not acceptable for Khmer women. However, for the reasons outlined above Cambodian men are unlikely to admit to masturbation. This secrecy limits masturbation as a valid sexual option for men like those in the uniformed services who are sometimes separated from their wives. This is relevant to HIV/AIDS prevention and to the situation of the uniformed services particularly. These beliefs and attitudes to masturbation may contribute to higher rates of penetrative sex generally - if masturbation is not an acceptable outlet for sexual frustration then sexual activity with a partner is the only option. For men in the uniformed services who may spend extended periods away from their partners this is particularly relevant as this attitude to masturbation may contribute to higher rates of penetrative sex with casual or paid sexual partners.

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<sup>27</sup> Tarr, C.M. Young People and HIV in Cambodia. AIDS CARE (1999) Vol. 11, No 3, pp 375-384.

# Factors Specific to the Uniformed Services

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## Culture of Masculinity

Historically, the uniformed services have been a man's world. Armed forces generally have few women and some have none. In many cultures, the fighting man is considered the epitome of masculinity, strong, brave and virile.<sup>28</sup> Some women serve in the Cambodian military, although their numbers are small and they make up around one per cent of the armed forces. There are no women in combat battalions and they are not trained to fight. Most women in the Cambodian armed forces are office workers, cooks and cleaners. There are some women in the Cambodian police force although again their numbers are relatively few. Female police officers carry out similar duties as their male colleagues and may carry a weapon.

The culture of masculinity in the military is widely recognized in armed forces around the world. In some countries, soldiers are considered the epitome of masculinity and this belief is widely reinforced in popular culture. Masculinity and sexual activity are strongly linked and in Cambodia, the dominant military culture equates visiting sex workers and multiple partners with being a real, strong man.<sup>29</sup> Studies among uniformed servicemen in Cambodia have found that the choice of sexual partner, the cost of sex and the frequency of extra-marital sex all contribute to a man's social standing among his peers. Sex with direct sex workers has little social kudos, while negotiating sex with sweethearts or karaoke women is preferred. The following quote from a recent CARE intervention in Koh Kong funded by FHI/USAID explains the dynamics of masculinity in the uniformed services:

*"Karaoke girls provide a casual sexual experience and help build sexual credibility among their peers. Karaoke girls are considered cleaner, less risk for HIV/AIDS, less likely to insist on condom use and more expensive than direct sex workers. This extra cost is an indicator of sexual status among the men. It is also important that men must negotiate sex directly with the karaoke girls. Karaoke workers do not perceive themselves as sex workers and they are reported to be able to choose their partners. The participants cannot simply walk into a karaoke bar, pick a girl to have sex with and then leave. There is a process of 'chasing' and negotiating that must take place."*<sup>30</sup>

For men in the Cambodian uniformed services as for other uniformed servicemen around the world, frequent sexual activity equals masculinity. In the man's world of the uniformed services, to be unmasculine is unthinkable. This represents a powerful pressure to engage in frequent sexual activity with a variety of partners, which increases the risk of HIV infection.

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<sup>28</sup> Combat AIDS (draft). Healthlink/PANOS, 2002.

<sup>29</sup> HIV/AIDS and the Military. Family Health International 2001.

<sup>30</sup> Sex is as Essential as Rice. CARE International in Cambodia. 2002.



## Working Away From Family

Mobility is common among the uniformed services in most countries. It is widely recognized that this mobility can increase risk behavior. When men are separated from regular sexual partners, they are more likely to engage in casual or paid recreational sex. Mobility is also a part of life for uniformed servicemen in Cambodia although this varies from place to place. In the RCAF, regiments are not based in a single location. The location changes at regular intervals in a practice that dates back to the civil war. Reorganization and redeployment are also common as regiments adjust their numbers to respond to needs within the country. There are frequent restructures in the RCAF as the armed forces change from war to a peacetime configuration. Demobilization also necessitates redeployment as regiments are removed or combined to bring them up to strength. In the recent past RCAF troops were still patrolling or pursuing the remnants of the Khmer Rouge in Cambodia's northwest. For these soldiers the return to barracks was a cause for celebration:

*"This is the nature of us soldiers. When we went to fight in the battle, we couldn't find any sex for a long time. But when we came to Battambang town and drank then we were happy together with promotion women."*

The police in Cambodia are less mobile and are generally assigned to a particular post long term. However, the intervention and protection police are possibly more mobile than their military peers. These police forces are deployed to different areas to respond to current civilian security concerns in the area and may spend considerable time away from their partners like the respondent below:

*"When we drink herbal wine then we feel that we need some fun by having sex to release our depression especially someone who are away from families."*

Apart from the mobility required by occupation there is another form of mobility brought about by Cambodia's mainly rural character. More than 80 percent of Cambodians live in rural areas and farming is overwhelmingly the most common occupation. Conversely, significant proportions of jobs in the police force are located in urban areas. Farming land is scarce and land laws are not respected. One aspect of Cambodia's Byzantine land law recognizes anyone living on land as the legal owner if they live there for more than five years. Dispossession and theft of land is common even when it is occupied. To ensure and protect title families must stay on the land they own. Therefore, for families with small plots of farming land, it is not feasible for families to move to the city and leave their land to accompany a husband who works in the uniformed services. This situation leaves many uniformed servicemen from rural areas separated from their families like the police respondent below:

*"I am also a motorcycle taxi driver. When I have money, I go out, get heavily drunk and have sex, because my wife lives far from me in the province."*

This rather bald factual statement shows how enforced separation, combined with cultural barriers to masturbation and the availability, acceptability and affordability of commercial sex make statements like the one from the police officer above normal in the Cambodian uniformed services.

## Additional Income

Despite the different status afforded to Khmer women within marriage, they are not silent partners. Traditionally the wife is responsible for managing the family finances. She considers income and expenditure and handles the family savings. Many Khmer husbands give their entire salaries to their wives and receive a small amount of money in return for daily expenses. The wife will keep this money and savings in cash or gold. Generally, income and expenditure must be carefully accounted for at home. Most Cambodian husbands cannot simply take money from the family coffers to buy alcohol and commercial sex. To afford these pursuits another source of income must be found.

Husbands are secretive about their extramarital affairs and fearful that their spouses will discover them. During HIV/AIDS education sessions with married men and women in Koh Kong, CARE found most husbands reported being very afraid that their wives would find out about their philandering.<sup>31</sup> This makes a source of cash income necessary to pursue paid sex. Uniformed servicemen like many government employees have opportunities to receive cash gratuities earned in addition to their government salaries.

This cash income comes with its own social obligations. For uniformed servicemen, money earned this way is rarely earned alone. Usually it is earned and must be shared with other servicemen, like a patrol guarding a border post or plantation. The money collected must be shared and a portion must be given to the immediate superior. However offering small sums of money to a superior may be considered insulting as it infers that the superior is impoverished. The common solution to this dilemma is a group outing to a restaurant or karaoke bar. The supervisor is invited and given plenty to eat or drink and a sex worker may be provided. Expenses for the evening are paid from the additional income.

This culture of gratuities is not a new phenomenon. It was a normal and accepted practice in Cambodia in pre-colonial times. Before the French protectorate, officials of the government were not paid salaries but were rewarded with a cut of the taxes, fees or product they collected for the crown. In addition, officials were able to use people of lower status for personal service or to produce items for sale. This practice continued until the sixties when government positions were ranked on a scale of desirability according to the private benefits that could be gained.<sup>32</sup> This practice had been modified in the last hundred years however, the practice of offering benefits to public servants continues today. The Royal Government of Cambodia acknowledges this problem and is working to decrease these practices in Cambodia, most recently through the creation of the national auditing authority.

This practice is deeply ingrained in Cambodian society and both the government and donors agree that it will take many years to control. In the meantime, it is important to recognize how gratuities and the rituals of sharing them contribute to the immediate danger of Cambodia's HIV/AIDS epidemic.

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<sup>31</sup> Interview with Kim Green HIV/AIDS Co-ordinator CARE International in Cambodia. 10/6/02.

<sup>32</sup> Michael Vickery. Cambodia 1975-1982. 1984.

## Personal Invulnerability

Military servicemen often have a greater sense of personal invulnerability than their civilian counterparts. This syndrome is common for troops in combat who can envisage or even witness the death of others but not believe they personally will be hurt. This belief can be a positive asset for soldiers particularly in dangerous situations. It can be a useful psychological defense and even essential to keep fear at manageable levels and allow soldiers to function efficiently in battle. If this psychological defense is removed, it can leave a soldier paralyzed by their fear of his own death in the syndrome commonly known as battle fatigue or more correctly post-traumatic stress disorder.<sup>33</sup> A belief in personal invulnerability is more common among soldiers who are frequently exposed to combat or other dangers than for rear echelon personnel. It is also more common in the military than among police although it may be present in either force.

In Cambodia, this sense of invulnerability may have spiritual or magical as well as psychological aspects. Many Khmer uniformed servicemen wear or carry munakum or magic to protect them from dangers in battle. Munakum is a part of Khmer culture. Many Khmer seek charms, talismans or adornments to cure specific illnesses, bring luck or prevent ill fortune for the bearer. There are specific adornments to deflect bullets and prevent the bearer from stepping on mines. These magic adornments come in many different forms. Sashes and small squares of red cloth inscribed with Sanskrit prayers are worn under a shirt or carried. There are also a variety of bracelets, belt and necklaces. These are made of thin sheets of lead inscribed with powerful phrases then rolled into a cylinder around a cord to make a belt, necklace or bracelet which is also worn under the clothing. Similar designs can be inscribed directly onto the skin as a tattoo or series of tattoos. A powerful magician or monk prepares these charms and the more powerful and famous the practitioner, the more efficacious the charm. Various animal parts are also carried or worn to provide luck and prevent harm. These may be inscribed with symbols or Sanskrit writing or may be unadorned. The most powerful materials for these charms are the tusks of a wild pig, tiger claws or a dried human fetus.

The effect of these talismans is powerful and can lead the wearer to feel virtually indestructible. When this potent protection is combined with alcohol, which is common for servicemen, the dangers of contracting HIV from unprotected sex may seem small by comparison. However, this sense of personal invulnerability, which may be an asset in combat, can be dangerous in sexual encounters. Uniformed servicemen who believe they cannot be harmed may discount or ignore the dangers of HIV and AIDS. This can lead to high-risk sexual encounters and unprotected sex.

## Culture of Risk Taking

Uniformed servicemen are required to take risks. Their roles and responsibilities are substantially different from the civilian population. A civilian confronted with an armed man threatening others may remove himself from danger immediately. However, a police officer in the same situation cannot. He is mandated to protect the public and resolve the situation despite the personal risks involved. Military servicemen are mandated to take even more risks.

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<sup>33</sup> (1987) Diagnostic and Statistical Manual of Mental Disorders III-R.

It is widely recognized that this familiarity with danger and risk can spill over into civilian pursuits. Many past and present uniformed servicemen continue to take voluntary risks when removed from the dangerous situations that they are mandated to face. Uniformed servicemen are trained, required and expected to face risks in their employment and indeed may be punished if they refuse. It is therefore not surprising that this attitude to danger can carry over to civilian pursuits.

It may be difficult for civilians to understand why a serviceman would have frequent unprotected sex with a sex worker in an area with high rates of HIV/AIDS infection. However, this risk is no greater and far less apparent than the risks inherent in advancing under enemy fire or confronting an armed thief. This attitude to danger means that educating uniformed servicemen about the personal dangers of HIV/AIDS alone is unlikely to be sufficient to motivate sexual behavior change.

## **Peer Pressure**

Peer pressure is a widely recognized social force that occurs when individuals are gathered together in groups. Individuals tend to behave in similar ways. This force is particularly strong in groups where conformity is required and expected, like the uniformed services. Peer pressure is a strong determinant of the behavior of men in the uniformed services due to the strong group bond and the emphasis on the group rather than the individual. As part of this strong group bond, military and police officers around the world tend to socialize together. In Cambodia, this socializing usually includes alcohol and sex.

Some respondents in the participant interviews conducted by FHI discussed the difficulty of not conforming to the wishes of the group. Peer pressure is particularly strong during drinking games when pressure to drink is intense. Not drinking when the rest of the group is yelling to drink is considered rude and other members of the group may insult the slow drinker's masculinity or even become angry. Peer pressure may also be associated with visiting sex workers. Some uniformed servicemen have reported being forced to enter brothels by their drunken peers. These may have been exaggerations or attempts to blame others for extramarital sex. However, they illustrate how uniformed servicemen perceive the power of pressure from their peers. The following quote is from a group discussion with police in Takmau:

*"For alcohol drink, I drink only to get drunk, as I told you that my friend persuades me to go eating. I speak frankly of you, you believe or not it doesn't matter. Since the year of 1993 I have never gone outside because I see that I have hepatitis C. Then they persuade me to go inside the room but I am not, I tell you the truth that I am not. When I went to drink with my friends and then they persuaded me to go, so I must go and when they force me to go inside I told the girl that I would do nothing, if she charges me it doesn't matter, it is the truth. I went to Svay Pak for two times. The first time I did not go inside and just sit on the sofa, so the girl does not come to see me. But I call her to come to massage and then when my friends finished and pay so the girl comes to see me. The second time, they force me but nobody knows that I do like this for four or five times. For doing massage I can not avoid but I did not have sex."*

In some cases, peer pressure goes beyond verbal exhortations to drink or have sex. The following quote illustrates a more serious pressure to conform.

*"I usually went for outside entertainment with my friends. Those friends of mine went to drink and then they enjoyed sex. Partly I didn't. In fact, they threatened me to have sex with a gun pointed at me, so I had to go inside the brothel for 10 or 15 minutes. But I didn't have sex and I asked the girl not to tell my friend. The girl was still paid by my friends."*

Whether exaggerated or not, these quotes demonstrate the power of peer pressure for Cambodian uniformed servicemen. This peer pressure complicates HIV prevention interventions that are designed to change high-risk sexual behaviors and make it necessary to change the norms of the group rather than the individual.

### **Excessive Alcohol Consumption**

Alcohol is one of the central dynamics in high-risk sexual behavior in the uniformed services. Heavy drinking has been consistently linked to increased sexual risk behavior among many groups including uniformed services. Alcohol increases courage, lowers inhibitions and impairs judgement making risk assessments less realistic. The following quote from an HIV positive serviceman illustrates the power of alcohol to impair sexual decision making.

*"When I am drunk sometime the girl wears the condom for me and I don't agree. If she wants me to wear a condom, I said that it is not necessary. This is when I am drunk. When I am not drunk, I have no courage like this. When I have sex, sometimes I have sex by using condom and sometimes I am drunk and I forget condoms. So now I have this disease, I have only this..."*

In Cambodia, alcohol is plentiful, cheap and there are no religious, cultural or legal restrictions on drinking. Alcohol is commonly available at all parties and celebrations and is part of some religious ceremonies. Drinking until drunk is common during religious and secular celebrations like weddings and festivals and has no major negative connotations. Many rural families make their own alcohol from palm sugar or rice. These beverages are around 30 or 40 per cent alcohol. One liter of srah sor or srah ongkor costs around 1200 Riel (about 30 cents) and can make one person very heavily drunk. A liter shared between two persons is more common for drinking sessions.

There are cultural restrictions on heavy drinking for women. However, drinking alcohol is considered part of the socialization process for young men. As in many countries around the world alcoholism is common among the very poor and among disadvantaged groups like the disabled. Consequently, heavy drinking is common for Cambodian men and very common in the uniformed services. In the sample of 135 police and military servicemen analyzed for this report, only two men reported that they did not join their friends in drinking sessions.

The discussion with uniformed servicemen analyzed for this report took place mainly in groups of six or more participants. Interviewers encouraged respondents to talk generally about their experience of drinking without asking many questions. The benefit of this unstructured approach was that respondents revealed a lot of information about whether they drank, if they went out for sex when they drank and whether they remembered to use a condom.

Firstly, participants were asked about their experience of drinking alcohol. Ninety-seven per cent of participants reported that they drank alcohol. Three per cent of participants reported that they did not drink either because they had a medical condition that prohibited drinking or because they did not like the taste. During the discussion, participants discussed how much alcohol they drank and whether they became drunk. The following table shows those participants who drank until they were drunk.

Category	Percent
Drink until drunk	63%
Not drunk/only drink a little	3%
Didn't say	34%
Total	100%

**Table 2: Do you drink until you are drunk?**

Most participants reported that they often drank until they were drunk. Some participants reported drinking until they lost consciousness as in the following quote from a police participant: *"We drink until we get drunk, fall down and the dog licks the drunken mouth."* Due to the unstructured nature of the group discussions, 34 percent of participants did not say whether they drank until they were drunk or not.

Respondents reported going out for sex and drinking as the two most common forms of outside entertainment. The combination of the two activities - drinking and then having sex was also common. The discussion of alcohol and sexual behavior presents the opportunity to explore this link further. The following table shows the number of respondents who reported going out for sex after drinking.

Category	Percent
Go out for sex	75%
No sex	9%
Didn't say	16%
Total	100%

**Table 3: Do you go out for sex after drinking?**

The majority of respondents reported that they went to have sex after drinking. This did not refer to going home to their wives. Respondents reported visiting a range of direct and indirect sex workers after drinking. Only nine per cent of participants said they did not have sex after drinking. Sixteen per cent of respondents did not state whether they had sex after drinking or not.



*"Every time I drink alcohol, I feel for sex immediately. I noticed that we were seemingly many ghosts and devils in our body, every time when we were drunk and didn't have sex, we feel very uncomfortable and desirable. Every time I saw any girls, I wanted to have sex with them shortly after."*

This result shows how strongly alcohol and extra-marital sex are linked for the uniformed services. As the discussions continued many participants volunteered information about condom use when they were drunk. The following table shows the results for those participants who stated that they went out for sex after drinking.

Category	Percent
Sometimes forget condom	22%
Always remember condom	20%
Use condom incorrectly	4%
Lose memory/lose control	10%
Didn't say	44%
Total	100%

**Table 4: Do you remember to use a condom when you have been drinking?**

Again as the discussion was unstructured, some respondents did not volunteer an answer. However, 22 per cent of respondents reported that they sometimes forgot to use a condom when they had been drinking as in the following quote from a military respondent:

*"When we drink and get drunk we do not think carefully. We did not need to use condoms. Instead we use our natural little brother that came at birth."*

Twenty per cent of respondents reported that they always remembered to use a condom even when they were drunk. A small number of respondents said that they used a condom but they used it incorrectly as in this example from another military respondent:

*"As we got drunk we forgot use condom use method that was explained thus it's so dangerous when the condom used were torn during sexual intercourse."*

Ten percent of respondents reported that they lost their memory or lost control when they were drunk. Finally, 44 per cent of respondents did not state whether they used a condom or not after they had been drinking.

Many of the experiences with alcohol reported during group discussions were very similar. From these similarities, it is possible to describe a typical scenario for these uniformed servicemen. The common scenario that emerged from these group discussions was of groups of uniformed servicemen going out together once or twice per month. This often happened after they had received their salary or one of a group of friends had received some additional money. They go out to eat and drink cheap alcohol like palm wine and herbal wine. They drink heavily and drink until they are heavily drunk. There is strong peer pressure to drink and drinking sessions usually end with the whole group adjourning to a brothel or karaoke bar with hostesses who are indirect sex workers. The majority of the group then chose girls and go to have sex. There is also peer pressure to have sex. One participant mentioned being forced at gunpoint into a bedroom with a prostitute. Condoms are worn if the man is not too drunk. If he is heavily drunk he may forget or decide to take the risk. Sometimes the prostitute will insist on a condom. This quote from a military respondent summarizes this scenario:

*"When we eat, then we are drunk and we always go to find the prostitute girls and sometime we don't use condoms."*

This kind of group drinking session is common in many uniformed services around the world not only Cambodia. However, the link between heavy drinking high-risk sexual behavior is particularly strong in Cambodia and is poorly recognized in the uniformed services.



# HIV/AIDS Factors

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## Risk Assessment Based on Partner's Appearance

Risk assessment is the internal weighing of pros and cons in a risky situation that accompanies the decision to undertake a course of action. People conduct risk assessments automatically and often. In HIV/AIDS work, it usually refers to weighing the pros and cons of a potentially risky sexual encounter to decide whether to have sex, to choose a sexual partner or to decide whether to use a condom. HIV risk assessments are a positive process that is encouraged in HIV/AIDS education. Teaching the basics of risk assessment can help people to lower their personal risk levels, make safer sexual decisions and decrease the chance of contracting HIV. However, when personal risk assessment is based on incorrect information risk can be increased rather than decreased. In the Cambodian uniformed services, personal risk assessments are often based on incorrect information leading to increased risk for servicemen. The following description of sexual risk assessment is from a police officer in Phnom Penh:

*"Because of my experience I used to know about this problem. There are some bruises around her groin, her vagina opens a bit widely and there is a bad smell there as well. These are the signs that make me decide not to have sex. I feel that if these things occurred I think that she obviously must have some infectious disease, so I dare not risk it. On the other hand, when we see her first we know she is pretty but if we embrace her for five or ten minutes we will get some bad smell from her vagina although it is washed. This is why people usually say that you shouldn't have sex when you get to the red light area with many pretty girls waiting for you. The girl that wants to keep her disease secret will wash her vagina. But if we do not have sex immediately, only tease her then after a while we get bad smell. So I don't have sex with her I just pay 5000 or 10,000 Riel whatever the normal price. I worry about HIV/AIDS because I am old and experienced. If she does not have HIV/AIDS, she must have another disease like syphilis or urethritis. Of course, I don't mean that I never go out for such entertainment. I go out half month, one month or two month periods."*

For this officer his personal risk assessment was based on the appearance and smell of the sex worker's vagina. However, there are many physical characteristics that uniformed servicemen believe can denote disease or infection. The following risk assessment is from a soldier in Kampong Cham:

*"To find our partner, she is beautiful or pretty depends on us. But when we enter the room and see beauty, then it can make us want to have sex. But we should palpitate the girl's body first. If it feels hot, don't have sex, should look for a new one. Sometimes diseases can present it's temperature that cause the body to feel hot."*

From the information gathered from the research, a number of common physical factors emerged that uniformed servicemen used to decide if a sexual partner might have a disease. Some factors are used to assess the probability of all sexual diseases including HIV while other are only for HIV. The following is a list of the most common physical factors reported by servicemen:

- A bad smell from the vagina = sexual disease. No smell = no disease
- Bleary or yellow eyes = sexual disease. Clear eyes = no disease
- Thin or skinny = HIV/AIDS. Plump or fat = no HIV/AIDS
- Hot skin = disease. Cool skin = no disease.

Apart from these physiological factors, uniformed servicemen commonly report other general factors that they use to determine the risk that a sexual partner may be infected with a sexually transmitted infection. Most of these are concerned with assessing the number of sexual partners that a woman may have had. The assumption is that fewer sexual partners equals low risk. The following quote from a soldier illustrates one of the most common methods of risk assessment reported by uniformed servicemen.

*"If I go to the brothel I select only the girl that is very ugly because I think the girl has not much disease and nobody uses her."*

Uniformed servicemen strongly believe that physically attractive woman are more likely to be infected. The woman's behavior is also believed to be an important indicator of potential risk as in the following quote from a police officer.

*"I like the girls who have quite attitudes, but not so much. If she sit for clients, she does not wave her hands or shout at the client for sex. I think that most of the men do not like those girls. Most men like the girls who quickly touch or feel them when they sit down and then those girls are more vulnerable to the disease."*

The following lists the general factors most commonly reported by uniformed servicemen to assess risk in sexual partners.

- Homely or ugly women = fewer sexual partners = no disease.  
Beautiful women = more sexual partners = disease
- Quiet modest women = fewer sexual partners = no disease.  
Loud outgoing or flirtatious women = more sexual partners = disease
- Younger sex workers = fewer sexual partners = no disease.  
Older sex workers = more partners = disease
- Newcomer to the brothel = fewer sexual partners = no disease.  
At the brothel for some time = more sexual partners = disease.
- Brothel based sex workers = more sexual partner = disease.  
ISW, sweethearts or widows = fewer sexual partners = no disease.

Many uniformed servicemen involved in participant research at FHI reported using these factors to make risk assessments about sexual partners. Some servicemen reported using a combination of factors to choose a safe partner like the following example.

*"Firstly I need any girl who is not much interested or attractive to others and secondly we need to see whether her eyes bleary eyed or not, or yellow. I will not take anyone who has any symptoms of these. This I am talking about the sex worker. If any of the sex workers has that symptom, she must probably have liver disease or other diseases. I don't get involved with any attractive girls, which are mostly sex involved with many different clients."*

In the group discussions among servicemen used in this report, virginity was frequently mentioned in the context of reducing HIV and AIDS risk. This is not surprising, as young virgin women would fulfill many of the criteria for low risk sexual partners listed above. In the discussions, virgin women were widely believed to be the ultimate in safe sex. This is probably related to studies among sex workers that report that virginity is frequently sold and that the demand for virgins as sex partners is increasing.<sup>34</sup> Some uniformed servicemen discussed the unlikely possibility that young women could have their virginity restored by surgery and had therefore developed their own methods of determining virginity as in the following quote from a military respondent.

*"From the beginning we can know if she is a virgin or not. Because a virgin is different from not virgin, that has already had another man or husband. We just hold her hand and we can know if she is a virgin or not. The hand of a woman who has never had sex is different from the hand of a woman who has had sex. If we know that she is a virgin, we use the method of husband to wife. We cannot use condom if we know that she is original."*

However, studies with sex workers also report that virginity is frequently sold several times often in different brothels. Unprotected sex is the norm during sex with these virgins and therefore is likely to be more risky than protected sex with non-virginal partners.

Uniformed servicemen commonly use a variety of factors to choose sexual partners and to make decisions about condom use. As factors to consider when assessing the probability of HIV infection in sentinel groups, these factors may be valid. More sexual contacts can increase the risk of contracting HIV. However, they are less suitable for assessing personal risk of HIV. Condom use is a much better predictor of HIV risk than number of sexual contacts. In fact, If these factors are widely used to make decisions about condom use, sex with these women may be more risky, than other sex workers who are considered high risk. If many Cambodian men have unprotected sex with women who are homely, quiet, young, new or ISWs these women may be more likely to have HIV than other women.

### **Ignorance about HIV Transmission Methods**

Ignorance about HIV/AIDS and particularly about the window period for HIV testing are contributing factors to high-risk behavior in the uniformed services. Since 1998, FHI has been implementing peer education programs among the military and in 2001 peer education began with the police. However, the peer education project does not yet have national coverage and many servicemen remain to be reached. The draft Situation and Response Analysis for HIV/AIDS in the military conducted by FHI notes a lack of knowledge and understanding about HIV and STI in many areas. This was particularly true in the remote areas of military regions I, IV and V.<sup>35</sup>

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<sup>34</sup> Center for Advanced Study, 2002.

<sup>35</sup> HIV/AIDS in the Military Draft situation and Response Analysis Report, 2001. FHI internal document.

## Acceptability and Availability of Condoms

Availability is an important and obvious determinant of condom use. When condoms are not available, they cannot be used. Furthermore, when it is difficult or embarrassing to carry or access condoms they are less likely to be used.

Thanks to the efforts of the government's 100% condom use policy, condoms are now widely available in brothels and guesthouses where direct sex workers and their clients are found. The 2001 FHI mid term program review of the uniformed services program found that condoms were readily available to uniformed servicemen in urban and rural market areas. However, condoms were not easily available in some remote uniformed service posts where there was an active commercial sex industry.<sup>36</sup>

Carrying condoms at all times, may be difficult for married uniformed servicemen who are concerned that their wives may discover them. As mentioned earlier, many Khmer men are afraid that their wives will discover that they have extra-marital sex. Sex and drinking sessions are carried out in secret, without the knowledge of wives or family. The following quote from a police officer describing his extra-marital sex illustrates the secrecy that surrounds purchasing commercial sex:

*"Mostly we go far from our house, mostly we are secret, not so open. When we got drunk, we must be secret from the other people too. I go with my friends who are in the army, we share money and we go to eat first."*

During the discussions with informants for this paper, two Khmer informants related anecdotes about the problems caused by carrying condoms. Both informants reported receiving a single condom as part of IEC distribution after HIV/AIDS training. After the male informants returned home from the training their wives discovered these condoms and immediately accused the men of having spent the day with another woman. The two male informants reported that they were able to resolve these misunderstandings through extended discussion. However, these anecdotes demonstrate the association of condoms with extra-marital sex. They also demonstrate the perils of always carrying condoms for unplanned sex, which has been a popular intervention strategy in other countries.

## Myths and Misconceptions about Condoms

Myths, misconceptions and rumors about condoms are common in Cambodia as in many developing countries. The extent of these myths and how strongly they effect condom use are the subject of some debate within the HIV/AIDS sector in Cambodia. Some idea of their extent can be inferred from the fact that most KAP studies around HIV/AIDS report some of these myths. The most prevalent myths reported by the uniformed servicemen interviewed by FHI concerned vengeful sex workers or partners who deliberately sabotage condoms as in the following example.

*"I think it is safer if we put the condom on ourselves. Because some naughty girls pinch or cut the condom. Somehow they resent their sweethearts or husbands and they feel sorry for getting disease. They need revenge for all men. Other thing is because they need to reach their orgasm."*

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<sup>36</sup> FHI/IMPACT Cambodia Mid-Term Review 2001.

These myths persist even after condom use education. They may even have been promoted by well meaning educators to scare men into safe condom use or away from extra-marital sex as the following example suggests.

*"We check the condom through the corner because it can be the girl who has AIDS she wants to transmit to us so that she can make hole, when we use we can get AIDS disease."*

The following lists some of the more prevalent and longstanding myths about condoms found in Cambodia.

- Condoms cause AIDS/are deliberately infected with AIDS.
- There is a cure for AIDS but the condom companies suppressed it.
- AIDS is a myth to boost condom sales.
- Condoms are pierced in the factory to spread AIDS.
- Vengeful HIV positive sex workers or partners pierce condoms.
- Condoms are weak and break frequently.

The list is probably not exhaustive however all of these myths are found in the uniformed services although not all servicemen believe them. Myths are generally less prevalent among servicemen who have received HIV/AIDS education and there is some evidence to suggest that they are more prevalent in remote areas of Cambodia. The most infamous of these rumors dates to the time when HIV/AIDS education and condom use were heavily promoted for the first time in the mid-nineties. The rumor relates to a disbelief of AIDS and suspicion about the large-scale promotion of condoms.

*"Some people said it doesn't have AIDS and don't be frightened, they just promote their condoms."*

This rumor has been largely discredited by increasing numbers of AIDS deaths and by free condom distribution. It is now mostly reported second hand as in the example above. There is no evidence to suggest that these rumors are a major determinant for condom use in the uniformed services. Indeed, it would be difficult to quantify their effect on decisions to use condoms. However, these misconceptions are part of the picture of high-risk sexual behavior in Cambodia and should be considered in order to understand the context for sexual decision making in the uniformed services.

### **Fear of Already Having HIV**

This factor hypothesizes that there may be a small group of uniformed servicemen who fear that they have contracted HIV but continue to have unprotected sex. This is similar to the myth mentioned above, that HIV positive sex workers continue working and encourage unprotected sex in order to gain revenge on men.

The hypothesis is that a core group of uniformed servicemen with a history of risky sexual behavior believe that they may have contracted HIV but refuse to take a blood test. To take the blood test and receive a positive result would be a shattering blow to the psyche and must be avoided at all costs. This sort of behavior is known in psychological terms as denial. One important aspect of denial is that the sufferer must not acknowledge the denial and continue behaving as before. For uniformed servicemen who believe they may already be infected this means continuing to have unprotected sex. The following quote is from a police respondent whose colleague recently died of AIDS:

*"In fact, he did not know himself positive because he didn't do blood test but he never used a condom when he had sex at Trol Labuakbek or Psar Kandal. When he knew himself to have a disease he started to feel very frightened and started to cure himself. Before he died, he dared not do blood testing for AIDS but he did testing for many other diseases. He never used a condom though he knew he had a disease."*

No other research was found to support this hypothesis during the literature search conducted for this paper and informants interviewed for the paper were divided on whether it was a contributing factor to high-risk behavior. It is included here for the sake of completeness and because the author, a psychologist, is firmly convinced that fear and denial are powerful determinants of behavior in Cambodia.



## Conclusions

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In the Cambodian uniformed services, sexual decision making happens in a personal and social context and not in isolation. Sexual behavior is influenced or even determined by the culture in which it takes place. In Cambodia, this means a culture with a history of change and instability, which has led to widespread fear and insecurity. It also includes a thriving, popular and affordable commercial sex industry. Sexual norms are different from many Western cultures and include widespread acceptance of extra-marital sex for men and powerful beliefs about the 'normal' way to have intercourse within marriage.

Sexual decision making in the uniformed services is influenced by factors that are common to uniformed services around the world. These include a masculine culture that encourages sexual adventures, working away from family, peer pressure and heavy drinking. Some factors are more peculiar to Cambodia and include the opportunities and obligations of additional income and feelings of personal invulnerability.

Finally, uniformed servicemen hold a variety of personal beliefs about HIV, condoms and other sexual diseases that heavily influence their sexual decision making. These include misconceptions and stigma around condoms, ignorance about HIV transmission methods and inadequate personal risk assessment criteria. These factors may have the most powerful influence of all and conversely may be the most amenable to change.

Successful HIV prevention in the uniformed services must consider these social, cultural, behavioral and personal factors to succeed. It must also consider the unique context of Cambodia. For example, HIV education messages that emphasize the possibility of dying years later are appropriate for countries where trust in the future is strong but are unlikely to motivate significant behavior change in Cambodia.

To summarize the discussions contained in the report, it seems obvious that exclusive approaches to HIV/AIDS prevention that focus on only one or two factors are unlikely to succeed. Sexual behavior and the determinants of behavior are complex, personal and multifaceted. Interventions for HIV/AIDS prevention and care need to consider the factors that affect these behaviors.

This paper does not aim to review existing approaches to HIV prevention in Cambodia or to outline the ideal approach. However, some important considerations for intervention design become apparent from the discussions of the factors in the body of the report. These considerations are listed here in the hope that they may be useful for HIV program design or review.

- In groups where peer pressure is a potent force like the uniformed services, interventions that aim to change group norms of behavior are more likely to be successful than those that focus only on individuals are.
- Interventions that focus on the immediate and short term impacts of HIV are more likely to be more relevant to Cambodian uniformed servicemen than dire warnings about death in the distant future.
- Personal sexual risk assessments need to be based on adequate correct information and not on myths or misinformation. Misconceptions that looking at, smelling or touching can be used to identify safe sexual partners increase the likelihood of HIV transmission. These misconceptions should be addressed in HIV prevention education.
- The link between drinking and impaired judgement or lowered inhibitions is quite well understood in Cambodia when it relates to driving vehicles or inappropriate behavior in public. However, the link between heavy drinking and increased risk of contracting HIV from extra-marital sex is not well understood. This is particularly true in the uniformed services, where heavy drinking is common. This link needs to be emphasized in HIV prevention programming.
- Sexual norms and attitudes to different sexual positions and masturbation contribute to the attraction of and rationalization for high-risk extra-marital sex. These are sensitive issues to address in HIV prevention but they are important components of HIV risk dynamics in Cambodia. Including wives in HIV prevention education and discussing sexual norms and attitudes are potential methods of tackling these factors.



## References

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- Cambodian Health Education Development, 1997. Knowledge, Attitudes and Practices Related to HIV and AIDS Among the Royal Cambodian Armed Forces. CHED, Phnom Penh Cambodia.
- Cambodia's Behavioral Surveillance Survey 1997-1999, Ministry of Health, National Centre for HIV/AIDS, Dermatology and STDs, February 2001
- CARE International in Cambodia. 2001. Interviews with Koh Kong karaoke workers in November and December 2001. Unpublished.
- CARE International in Cambodia. 2002. Sex is as Essential as Rice: Koh Kong Uniformed Servicemen's Attitudes to Sex, Condom Use, HIV/AIDS/STI and General Health Services. (draft). CARE Phnom Penh, Cambodia.
- Center for Advanced Study. 2002. Survey on Health Seeking Behavior of Women Working in the Entertainment Sector in Phnom Penh. CAS Phnom Penh, Cambodia.
- Combat AIDS. HIV and the World's Armed Forces. (Draft). 2002. Healthlink Worldwide and PANOS, London, England.
- Commercial Sexual Exploitation of Women and Children in Cambodia. Personal Narratives: A Psychological Perspective (Discussion Draft) 1996. Physicians for Human Rights. Boston, United States.
- Diagnostic and Statistical Manual of Mental Disorders, Third edition - Revised 1987. American Psychiatric Association. Washington, United States.
- Family Health International/IMPACT, 2000. Draft Concept Paper on Developing a Comprehensive Package for Uniformed Services. FHI internal document.
- Family Health International, 2002. Review of Qualitative Participatory Evaluation with Uniformed Service Officers. Internal document. FHI Cambodia.
- Family Health International, 2001. Sexually Transmitted Infection Prevalence Survey Cambodia 2001: Military. Phnom Penh, Cambodia.
- Family Health International, 2001. HIV/AIDS and the Military in the Kingdom of Cambodia. Draft Situation and Response Analysis Report. Phnom Penh, Cambodia.
- Family Health International, 2001. Concept Paper on Expanding the Military PE Project to military Region 4 and 5 and piloting a decentralised regional approach to expansion of the PE project. FHI internal document. Phnom Penh Cambodia
- Family Health International/IMPACT, 2001. FHI/IMPACT - Cambodia Mid Term Review March 2001. FHI internal document. Phnom Penh, Cambodia.
- Gaydos et al., 2000. The Challenge of Sexually Transmitted Diseases for the Military: What Has Changed? *Clinical Infectious Diseases*, 2000 Vol. 30 pp. 719-22.

- Gorbach et al. Sexual Bridging by Cambodian Men, July 2002. *Sexually Transmitted Diseases* Vol. 27, no 6 pp. 320-6.
- Greenwood, Z and Francis, C, 2001. A Good Wife: Discussions with Married Women about Life, Health, Marriage and Sexuality. Phnom Penh: CARE International in Cambodia.
- Greenwood, Z. 2000. I'm Not Afraid of AIDS, I'm Afraid of No Sex: Work, life and sex among motor taxi drivers in Koh Kong, Cambodia. Phnom Penh: CARE International in Cambodia
- Greenwood, Z. 2000. Sea and Shore: An exploration of the Life, Health and Sexuality of Koh Kong's Fishermen. Phnom Penh: CARE International in Cambodia.
- Greenwood, Z. 1999. When the Stars are Up: Life and work of sex workers in Koh Kong. Phnom Penh: CARE International in Cambodia.
- Guest, P. 2000. Population Mobility in Asia and the Implications for HIV/AIDS in *Population Mobility in Asia: Implications for HIV/AIDS Action Programmes*, April 2000, p.77
- Jenkins et al. 2000. Reducing Risk of Sexually Transmitted Disease (STD) and Human Immunodeficiency Virus Infections in a Military STD Clinic: Evaluation of a Randomized Preventative Intervention Trial. *Clinical Infectious Diseases*, 2000 Vol. 30 pp. 730-5.
- Kamm, H. 1998. Cambodia - Report from a Stricken Land. Arcade Publishing, New York, United States.
- Maclean, A. 1999. Sewing a Better Future? A report of discussions with young garment factory workers about life, work and sexual health. Phnom Penh: CARE International in Cambodia
- Maclean, A and Francis, C. 1999. Dangerous Places: A discussion of the process and findings of PLA research with policemen in Svay Rieng, Cambodia. Phnom Penh: CARE International in Cambodia.
- Ministry of Health, 1999. Report on Sentinel Surveillance in Cambodia. NCHADS, Phnom Penh, Cambodia.
- Ministry of Health, 2000. Report on HIV Sentinel Surveillance in Cambodia. NCHADS, Phnom Penh, Cambodia.
- Ministry of Health, 2000. Cambodian Household Male Survey: BSS IV 2000. NCHADS. Phnom Penh, Cambodia.
- Ministry of Health, 1999. Cambodia's Behavioral Surveillance Survey 1997-1999. NCHADS, Phnom Penh, Cambodia.
- Ministry of Health, 2000. Draft Background Paper on RTI/STI/HIV in Cambodia. Phnom Penh, Cambodia.

Ministry of Health, 2002. Cambodia's Behavioral Surveillance Survey V 2001: Trends from BSS I-V 1997-2001. NCHADS, Phnom Penh, Cambodia.

Ministry of Health, 2002. HIV Sentinel Surveillance 2002. NCHADS, Phnom Penh, Cambodia.

Ministry of National Defense, 2001. Field Visit Report on HIV/AIDS Situation and Response Analysis: Stung Treng Province. MoND, General Department of Logistics and Finance, Department of Health. Phnom Penh, Cambodia.

Ministry of National Defense, 2001. Field Visit Report on HIV/AIDS Situation and Response Analysis: Prey Veng Province. MoND, General Department of Logistics and Finance, Department of Health. Phnom Penh, Cambodia.

Ministry of National Defense, 2001. Field Visit Report on HIV/AIDS Situation and Response Analysis: Pailin and Battambang. MoND, General Department of Logistics and Finance, Department of Health. Phnom Penh, Cambodia.

Ministry of National Defense, 2002. HIV/AIDS Strategic Plan 2002-2006 (Draft). MoND, General Department of Logistics and Finance, Department of Health. Phnom Penh, Cambodia.

McKee et al. Features of Urethritis in a Cohort of Male Soldiers. 2000. *Clinical Infectious Diseases*, 2000, Vol. 20 pp. 736-41

Moller, J. and Yean Sourneak. 2001. Entertainment Workers and HIV/AIDS: An appraisal of HIV/AIDS related work practices in the informal entertainment sector in Cambodia. Phnom Penh: KHANA.

National AIDS Authority, 2001. National Strategic Plan for a Comprehensive and Multisectoral Response to HIV/AIDS 2001-2005. NAA, Phnom Penh, Cambodia.

Nopkesorn et al. 1998. HIV-1 Subtype E Incidence and Sexually Transmitted diseases in a Cohort of Military Conscripts in Northern Thailand. *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*. Vol. 18, pp. 372-39.

Nopkesorn et al. HIV-1 Infection in Young Men in Northern Thailand. 1993. *AIDS* Vol. 7 No 9 pp. 1233-1239.

Phan, H. and Patterson, L. 1994. Men are Gold, Women are Cloth: A report on the potential for HIV/AIDS spread in Cambodia and implication for HIV/AIDS education. Phnom Penh: CARE International in Cambodia.

Program for Appropriate Technology in Health, 2002. Assessment of Official Private Providers and Delivery of Health Care Services to Children Under Five. PATH, Phnom Penh, Cambodia.

Save the Children Fund (UK), 1997. Young People, HIV/AIDS and Sexual Health Project. Survey of Knowledge, Attitudes and Practices.

Sena et al. 2000. Trends of Gonorrhea and Chlamydial Infection during 1985-1996 among Active-Duty Soldiers at a United States Army Installation. *Clinical Infectious Diseases* 2000, Vol. 30, pp742-8.

Strategic Plan for HIV/AIDS and STI Prevention and Care in Cambodia 2001-2005, Ministry of Health, Cambodia, October 2001

Tarr, C. M, 1996. Study of Contextual Factors Affecting Risk-Related Sexual Behavior Among Young People in Cambodia. Final Report. Cambodian AIDS Social Research Project. Phnom Penh, Cambodia.

Tarr, C. M, 1996. People In Cambodia Don't Talk About Sex, They Simply Do It! Cambodian AIDS Social Research Project. Phnom Penh, Cambodia.

Tarr, C. M, 1997. Imagining Desire: the sexual cultures of paid recreational sexual activity between young Vietnamese women and their young Cambodian male clients. Issues paper prepared for the second technical consultation on transnational population movement and HIV/AIDS in South East Asian Countries.

Tarr, C. M and Aggleton, P. 1999. Young People and HIV in Cambodia: meanings, contexts and sexual cultures. *AIDS Care* 1999, Vol. 11, No 3, pp. 375-384.

UNAIDS, 1998. AIDS and the Military: UNAIDS point of view.

United Nations Development Fund for Children. 2001. Speaking Out! Voices of Children and Adolescents in East Asia and the Pacific, a regional opinion survey. UNICEF East Asia and Pacific Regional Office, Bangkok, Thailand.

Vathanak, O. 1999. Unsafe Sexual Practices and its Correlates Among Commercial Sex Worker in Phnom Penh Cambodia. Master's Thesis, Mahidol University. Bangkok, Thailand.

Vickery, M. 1984. Cambodia 1975 - 1982. Silkworm Books. Chaing Mai, Thailand

World Health Organisation, 2001. Mission Report by Dr. Tawesak Nopkesorn. First draft of a five year strategic plan for STI/HIV/AIDS prevention and care at the Ministry of National Defense. WHO internal document.

Yeager et al. 2000. International Military Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome Policies and Programs: Strengths and Limitations in Current Practice. *Military Medicine*, Vol. 165 2000, pp. 87-92.



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